

1 KAMALA D. HARRIS
Attorney General of California
2 KAREN B. CHAPPELLE
Supervising Deputy Attorney General
3 SYDNEY M. MEHRINGER
Deputy Attorney General
4 State Bar No. 245282
300 So. Spring Street, Suite 1702
5 Los Angeles, CA 90013
Telephone: (213) 897-2537
6 Facsimile: (213) 897-2804
E-mail: Sydney.Mehringer@doj.ca.gov
7 *Attorneys for Complainant*

8 **BEFORE THE**
9 **BOARD OF REGISTERED NURSING**
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

11 In the Matter of the Accusation Against:
12 **JUDITH ANN DAVIS**

Case No. *2013-545*

13 **Address of Record:**
14 **560 Hansen Ave. S**
Salem, OR 97302

A C C U S A T I O N

15 **Additional Address:**
16 **3497 Robert Ave., NE**
Salem, OR 97301

17 **Registered Nurse License No. 215139**
Public Health Nurse Certificate No. 55504

18 Respondent.

19
20 Complainant alleges:

21 **PARTIES**

22 1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her
23 official capacity as the Executive Officer of the Board of Registered Nursing, Department of
24 Consumer Affairs.

25 2. On or about June 30, 1971, the Board of Registered Nursing ("Board") issued
26 Registered Nurse License Number 215139 to Judith Ann Davis ("Respondent"). The Registered
27 Nurse License expired on September 30, 2002, and has not been renewed.
28

1 (b) A licensee may renew a license that has been expired for more than eight
2 years by paying the renewal and penalty fees specified in Section 1417 and providing
3 evidence that he or she holds a current valid active and clear registered nurse license
in another state, a United States territory, or Canada, or by passing the Board's current
examination for licensure."

4 STATUTES

5 9. Section 2761 of the Code states:

6 "The board may take disciplinary action against a certified or licensed nurse or deny an
7 application for a certificate or license for any of the following:

8 "(a) Unprofessional conduct, which includes, but is not limited to, the following:

9

10 "(4) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action
11 against a health care professional license or certificate by another state or territory of the United
12 States, by any other government agency, or by another California health care professional
13 licensing board. A certified copy of the decision or judgment shall be conclusive evidence of that
14 action."

15 COST RECOVERY

16 10. Section 125.3 of the Code provides, in pertinent part, that the Board may request the
17 administrative law judge to direct a licentiate found to have committed a violation or violations of
18 the licensing act to pay a sum not to exceed the reasonable costs of the investigation and
19 enforcement of the case, with failure of the licentiate to comply subjecting the license to not being
20 renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be
21 included in a stipulated settlement.

22 CAUSE FOR DISCIPLINE

23 (Discipline by the Oregon Board of Nursing)

24 11. Respondent is subject to disciplinary action under Code section 2761, subdivision
25 (a)(4) on the grounds of unprofessional conduct because her Oregon registered nursing license
26 was disciplined as follows:

27 12. On or about April 23, 2009, in a case entitled *In the Matter of Judith Ann Davis, RN,*
28 *No 200242598RN*, Case No. 09-125, the Oregon State Board of Nursing ("Oregon Board") issued

1 a Final Order which adopted a Stipulation for 60-Day Suspension with Conditions, thereby
2 suspending Respondent's registered nursing license for 60 days. In the Stipulation, Respondent
3 admitted to the following facts:

4 (a) Respondent became employed by Catholic Community Services as a registered
5 nurse on February 11, 2008. Her duties included planning, supervising, and implementing
6 nursing services for people with developmental disabilities. Respondent was the primary nurse
7 for one home with five residents and provided nursing supervision for a second home that had
8 licensed practical nurses on duty.

9 (b) On August 14, 2008, the Department of Human Services ("DHS") conducted a
10 site survey. DHS concluded that Respondent failed to implement physician's orders for resident
11 CG when she failed to administer a physician ordered ear irrigation medication. From February
12 13, 2008 through July 7, 2008, CG experienced periodic dehydration and evaluated temperatures.
13 On seven occasions, when CG experienced changes in physical condition, Respondent failed to
14 document a nursing assessment of CG and failed to document modifications of the nursing care
15 plan.

16 (c) DHS concluded that Respondent failed to document and complete a nursing
17 assessment and care plan for resident JR. From February 11, 2008 through August 1, 2008,
18 Respondent provided nursing oversight for JR. Respondent did not conduct an initial nursing
19 assessment on February 11, 2008. JR experienced increased redness and irritation to his stoma
20 and lost weight. On July 24, 2008, direct care staff noted a problem with the stoma. Respondent
21 failed to document a nursing assessment and failed to modify the nursing care plan or modify the
22 delegation instructions for JR's stoma care to reflect the nursing care JR was to be given.

23 (d) Resident LB experienced a painful left knee. Respondent failed to document
24 that she conducted a nursing assessment or that she responded to direct care staff's requests for
25 Respondent to evaluate LB. On July 31, 2008, it was determined that LB had a fracture of her
26 upper left tibia. Respondent failed to document a nursing assessment or change LB's nursing
27 care plan to reflect new nursing care needs.

1 (e) On March 10, 2008, Respondent changed the delegated task for G-Tube
2 Feeding and Medications for LB to an assigned task. There is no provision in the Oregon Nurse
3 Practice Act to change a delegated task of nursing to an assignment.

4 (f) On April 16, 2008, direct care staff wrote that resident CR had a significant
5 elevation in her temperature and discolored mucus. Respondent failed to document that she
6 conducted a physical assessment of CR. On April 30, 2008, CR's temperature spiked, was taken
7 to the hospital, diagnosed with possible pneumonia, and placed on antibiotics. Direct care staff
8 noted that Respondent was made aware of the situation but Respondent failed to document that
9 she conducted a nursing assessment when CR returned to the home.

10 (g) From June 9, 2008 through July 24, 2008, direct care staff left messages for
11 Respondent that patient AS had a red, painful, draining stoma. Respondent failed to document
12 that she responded to these messages or conducted a nursing assessment. Respondent failed to
13 modify the nursing care plan or the delegation instructions for AS's stoma care.

14 (h) On January 2, 2008, Respondent documented that she reviewed the previous
15 nursing delegation's specific step by step outline of how a task of nursing is to be performed for
16 patients living at the home. However Respondent was not employed on January 2, 2008.

17 (i) Respondent acknowledged that she was not educationally prepared or clinically
18 competent to delegate specific tasks of nursing care to unlicensed persons. Respondent failed to
19 provide timely initial assessment and direction to unlicensed caregivers. Respondent failed to
20 change and/or update the nurse delegation when the condition of a resident changed and required
21 a change in procedure. Respondent failed to rescind or transfer the nurse delegations when her
22 employment ended.

23 PRAYER

24 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,
25 and that following the hearing, the Board of Registered Nursing issue a decision:

26 1. Revoking or suspending Registered Nurse License Number 215139, issued to Judith
27 Ann Davis;
28

2. Revoking or suspending Public Health Certificate Number 55504, issued to Judith Ann Davis;

3. Ordering Judith Ann Davis to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and

4. Taking such other and further action as deemed necessary and proper.

DATED:

January 8, 2013

Stacie Ben

LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

LA2012508253
51200512.doc